FD-0429-0599

STATE EMPLOYEES **SEDCP** DEFERRED COMPENSATION PLAN

STATE OF NEW JERSEY — DIVISION OF PENSIONS AND BENEFITS
AUTHORIZATION FOR DIRECT DEPOSIT OF BENEFIT PAYMENT

MAIL TO: Direct Deposit
Deferred Compensation
Division of Pensions
and Benefits
PO Box 295
Trenton, NJ 08625–0295

INSTRUCTIONS:

A: Read the terms and conditions listed below.
B: Enter your name, mailing address, Social Security number, and home telephone number.
C: Indicate the type of account and print the transit routing and account numbers.
D: You and all other parties to this account must sign the form.
E: Attach a VOIDED check and return the completed form to the mailing address above.

RECIPIENT INFORMATION

Name: _____ **Social Security No:** _____

Address: _____ **Home Phone No: (_____)** _____

_____

_____
PLEASE PRINT LEGIBLY

REASON FOR REQUEST:

☐ **BEGIN DIRECT DEPOSIT** ☐ **CHANGE OF FINANCIAL INSTITUTION** ☐ **CHANGE ACCOUNT NUMBER**

TYPE OF ACCOUNT: ☐ **CHECKING** ☐ **SAVINGS** _____
NAME OF FINANCIAL INSTITUTION

_____ _____
TRANSIT ROUTING NUMBER **ACCOUNT NUMBER**

_____ _____
SIGNATURE OF BENEFIT RECIPIENT **DATE**

_____ _____ _____
SIGNATURES OF OTHER PERSONS ON ACCOUNT

Please read the terms and conditions below and
ATTACH A VOIDED CHECK FROM THE AUTHORIZED ACCOUNT
(used to verify your bank transit routing and account number)

TERMS AND CONDITIONS

Benefit Recipient

I authorize the New Jersey Division of Pensions and Benefits and the financial institution indicated to directly deposit my net Deferred Compensation benefit payment each month to the account specified. Direct deposit under this authorization is full satisfaction and discharge of the amount then due and payable under the benefit program. I understand that any retirement allowance or benefit payment forwarded to the financial institution with a due date after my death will be refunded to the benefit program. I agree that the financial institution shall have the right of offset for such a refund.

I further understand that this agreement may be terminated by me upon written notification to the Division of Pensions and Benefits. The cancellation will be processed for the pay period following receipt of the notice by the Division. I understand that a change in the title of this account which alters the interest of any party terminates this authorization and a new form must then be submitted to continue direct deposit. I understand that it is my responsibility to inform the Division of Pensions and Benefits of address changes immediately. I authorize the financial institution to provide the Division of Pensions and Benefits with my home address.

Other Parties to the Account

As a party to this account, I understand that I am personally liable, both individually and as a member of the group of parties to this account, for the full amount of all benefit payments with due dates after the death of the benefit recipient withdrawn from the account. This liability is to the benefit program. If I am entitled to any payment from the benefit program as a beneficiary of the benefit recipient, the amount of my liability may be deducted from the amount payable to me. I agree that the financial institution shall have the right of offset for such a refund and I authorize the financial institution to provide the Division of Pensions and Benefits with my home address.